		FOR OHF USE					

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0035469

Facility Name: Walter Lawson Children's Home

Address: 1820 Walter Lawson Drive (Number) Loves Park (City) 61111 (Zip Code)

County: Winnebago

Telephone Number: (815) 633-6636 **Fax #** (815) 633-6387

IDPA ID Number: 31-1262572

Date of Initial License for Current Owners: 08/15/89

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	501 (c) (3)		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: James R. Johnson **Telephone Number:** (859) 255-0075

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/02 to 06/30/03 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) James R. Johnson
(Title) V.P. of Finance - Medical Rehabilitation Centers, Inc.

Paid Preparer

(Signed) See Compilation Report (Date)
(Print Name and Title) Robert A. Thomas, Partner
(Firm Name & Address) Thomas Healthcare Consulting, P.C., 11988 Fishers Crossing Dr., Suite 200, Fishers, IN 46038
(Telephone) (317) 577-0101 Fax # (317) 577-3389

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Walter Lawson Children's Home # 0035469 Report Period Beginning: 07/01/02 Ending: 06/30/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2	93	Skilled Pediatric (SNF/PED)	93	33,945	2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	93	TOTALS	93	33,945	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED	30,159	806		30,965	9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	30,159	806		30,965	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.22%

D. How many bed-hold days during this year were paid by Public Aid?
426 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 08/15/89

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 08/15/89 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified 0 and days of care provided N/A

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL	MODIFIED CASH*	CASH*
[X]	[ ]	[ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 06/30/03 Fiscal Year: 06/30/03

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Walter Lawson Children's Home # 0035469 Report Period Beginning: 07/01/02 Ending: 06/30/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	174,928	31,558	9,332	215,818		215,818	(79,149)	136,669			1
2	Food Purchase		162,743		162,743		162,743		162,743			2
3	Housekeeping	182,857	16,402	1,052	200,311		200,311		200,311			3
4	Laundry	86,277	14,861	414	101,552		101,552		101,552			4
5	Heat and Other Utilities			61,364	61,364		61,364		61,364			5
6	Maintenance	51,682	5,289	23,062	80,033	4,534	84,567		84,567			6
7	Other (specify):*											7
8	**TOTAL General Services**	495,744	230,853	95,224	821,821	4,534	826,355	(79,149)	747,206			8
	B. Health Care and Programs											
9	Medical Director			11,205	11,205		11,205		11,205			9
10	Nursing and Medical Records	2,202,117	97,941	14,574	2,314,632	101	2,314,733		2,314,733			10
10a	Therapy	56,083		35,760	91,843		91,843		91,843			10a
11	Activities	82,485	764	496	83,745		83,745		83,745			11
12	Social Services											12
13	Nurse Aide Training											13
14	Program Transportation		1,367	2,235	3,602	(389)	3,213	(75)	3,138			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,340,685	100,072	64,270	2,505,027	(288)	2,504,739	(75)	2,504,664			16
	C. General Administration											
17	Administrative	93,228		138,754	231,982	(137,718)	94,264	(1,036)	93,228			17
18	Directors Fees					7,995	7,995		7,995			18
19	Professional Services			359,531	359,531	38,309	397,840		397,840			19
20	Dues, Fees, Subscriptions & Promotions			10,873	10,873	279	11,152		11,152			20
21	Clerical & General Office Expenses	67,638	13,356	14,398	95,392	32,692	128,084	(1,081)	127,003			21
22	Employee Benefits & Payroll Taxes			622,054	622,054	5,893	627,947		627,947			22
23	Inservice Training & Education											23
24	Travel and Seminar			14,373	14,373	1,798	16,171	(4,597)	11,574			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			30,937	30,937		30,937		30,937			26
27	Other (specify):*			800	800		800	(800)				27
28	**TOTAL General Administration**	160,866	13,356	1,191,720	1,365,942	(50,752)	1,315,190	(7,514)	1,307,676			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,997,295	344,281	1,351,214	4,692,790	(46,506)	4,646,284	(86,738)	4,559,546			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Walter Lawson Children's Home #0035469 Report Period Beginning: 07/01/02 Ending: 06/30/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			130,422	130,422	17	130,439		130,439			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			406,977	406,977	51,023	458,000	(28,165)	429,835			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			12,777	12,777		12,777	(1,314)	11,463			35
36	Other (specify):* Amortization			23,846	23,846		23,846	(13,684)	10,162			36
37	TOTAL Ownership			574,022	574,022	51,040	625,062	(43,163)	581,899			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			318,388	318,388		318,388		318,388			42
43	Other (specify):* Educ/Day Training	778,611	5,860	57,834	842,305	(4,534)	837,771		837,771			43
44	TOTAL Special Cost Centers	778,611	5,860	376,222	1,160,693	(4,534)	1,156,159		1,156,159			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,775,906	350,141	2,301,458	6,427,505		6,427,505	(129,901)	6,297,604			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Walter Lawson Children's Home # 0035469 Report Period Beginning: 07/01/02 Ending: 06/30/03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(28,165)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(800)	27		24
25	Fund Raising, Advertising and Promotional	(800)	21		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(281)	21		28
29	Other-Attach Schedule	(98,819)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (128,865)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(1,036)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (1,036)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (129,901)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39		X		SNF/PED		39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Walter Lawson Children's Home

ID# 0035469

Report Period Beginning: 07/01/02

Ending: 06/30/03

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	School Lunch Program	$ (79,149)	1	1
2	Amortization Goodwill	(13,684)	36	2
3	Personal Use of Vehicle	(1,314)	35	3
4	Personal Use of Vehicle	(75)	14	4
5	Non-Allowable Travel	(3,207)	24	5
6	Out-of-State Travel	(1,390)	24	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(98,819)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Walter Lawson Children's Home # 0035469 Report Period Beginning: 07/01/02 Ending: 06/30/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(79,149)	0	0	0	0	0	0	0	0	0	0	(79,149)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(79,149)	0	0	0	0	0	0	0	0	0	0	(79,149)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(75)	0	0	0	0	0	0	0	0	0	0	(75)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(75)	0	0	0	0	0	0	0	0	0	0	(75)	16
	C. General Administration													
17	Administrative	0	(1,036)	0	0	0	0	0	0	0	0	0	(1,036)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(1,081)	0	0	0	0	0	0	0	0	0	0	(1,081)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(4,597)	0	0	0	0	0	0	0	0	0	0	(4,597)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(800)	0	0	0	0	0	0	0	0	0	0	(800)	27
28	**TOTAL General Administration**	(6,478)	(1,036)	0	0	0	0	0	0	0	0	0	(7,514)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(85,702)	(1,036)	0	0	0	0	0	0	0	0	0	(86,738)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Walter Lawson Children's Home** **# 0035469** **Report Period Beginning:** **07/01/02** **Ending:** **06/30/03**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(28,165)	0	0	0	0	0	0	0	0	0	0	(28,165)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	(1,314)	0	0	0	0	0	0	0	0	0	0	(1,314)	35
36	Other (specify):*	(13,684)	0	0	0	0	0	0	0	0	0	0	(13,684)	36
37	**TOTAL Ownership**	(43,163)	0	0	0	0	0	0	0	0	0	0	(43,163)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(128,865)	(1,036)	0	0	0	0	0	0	0	0	0	(129,901)	45

Facility Name & ID Number Walter Lawson Children's Home # 0035469 Report Period Beginning: 07/01/02 Ending: 06/30/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		Swann Special Care Center	Champaign			
		Exceptional Care & Training Center	Sterling			
		Vernon Manor Children's Home	Wabash, Indiana			
		Richland-Bean Blossom HCC	Ellettsville, Indiana			
		Hanover Nursing Center	Hanover, Indiana			
		Clay County Nursing Center	Brazil, Indiana			
		Randolph Nursing Home	Winchester, Indiana			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Corporate Expenses	$ 138,754	Hoosier Care, Inc.	100.00%	$ 137,718	$ (1,036)	1
2	V								2
3	V				Note: See schedule VIII of allocation of cost per column 7.				3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 138,754			$ 137,718	$ * (1,036)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Walter Lawson Children's Home # 0035469 Report Period Beginning: 07/01/02 Ending: 06/30/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Bruce Hutson, M.D.	Director	Board Meetings	0.00	7,932			Director Fees	$ 1,599	18.8	1
2	Stephen Wood	Director	Board Meetings	0.00	7,932			Director Fees	1,599	18.8	2
3	John Gillmor	Director	Board Meetings	0.00	7,932			Director Fees	1,599	18.8	3
4	John Foos	Director	Board Meetings	0.00	7,931			Director Fees	1,599	18.8	4
5	Michael Conn	Director	Board Meetings	0.00	7,932			Director Fees	1,599	18.8	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 7,995		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Walter Lawson Children's Home # 0035469 Report Period Beginning: 07/01/02 Ending: 06/30/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Hoosier Care, Inc.
Street Address: 535 West Second, Suite 105
City / State / Zip Code: Lexington, KY 40508
Phone Number: (859) 255-0075
Fax Number: (859) 281-5150

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	Nursing / Medical Records	Revenue	39,559,967	8	$ 600	$ 0	6,636,759	$ 101	1
2	18	Director's Fees	Revenue	39,559,967	8	47,654	0	6,636,759	7,995	2
3	19	Professional Fees	Revenue	39,559,967	8	228,347	0	6,636,759	38,309	3
4	20	Fees,Subscription & Promotion	Revenue	39,559,967	8	622	0	6,636,759	104	4
5	21	Clerical & General Office Exp.	Revenue	39,559,967	8	194,869	0	6,636,759	32,692	5
6	22	Emp. Benefits & Payroll Tax	Revenue	39,559,967	8	36,172	0	6,636,759	6,068	6
7	24	Travel & Seminar	Revenue	39,559,967	8	8,397	0	6,636,759	1,409	7
8	30	Depreciation	Revenue	39,559,967	8	99	0	6,636,759	17	8
9	32	Interest Expense	Revenue	39,559,967	8	304,134	0	6,636,759	51,023	9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 820,894	$		$ 137,718	25

Facility Name & ID Number Walter Lawson Children's Home # 0035469 Report Period Beginning: 07/01/02 Ending: 06/30/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	City of Loves Park - 1999A		X	Purchase of Facility	Varies	07/08/99	$ 5,500,000	$ 5,335,000	06/01/2034	7.1250	$ 382,345	1
2	City of Loves Park - 1999B		X	Purchase of Facility	Varies	07/08/99	250,000	230,000	06/01/2019	10.5000	24,632	2
3												3
4												4
5												5
	Working Capital											
6	Home Office Allocation										51,023	6
7												7
8												8
9	TOTAL Facility Related						$ 5,750,000	$ 5,565,000			$ 458,000	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 5,750,000	$ 5,565,000			$ 458,000	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # N/A

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Walter Lawson Children's Home # 0035469 Report Period Beginning: 07/01/02 Ending: 06/30/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1998	None	8
	1999		9
	2000		10
	2001		11
	2002		12

Note: The facility became exempt from property taxes starting 01/01/96.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Walter Lawson Children's Home COUNTY Winnebago

FACILITY IDPH LICENSE NUMBER 0035469

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number Walter Lawson Children's Home # 0035469 Report Period Beginning: 07/01/02 Ending: 06/30/03

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 21,182 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	SNF/PED	217,364	1989	$ 665,000	1
2			1997	19,428	2
3	TOTALS	217,364		$ 684,428	3

Facility Name & ID Number Walter Lawson Children's Home # 0035469 Report Period Beginning: 07/01/02 Ending: 06/30/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	93		1989	1971	$ 2,917,000	$ 63,425	10-40	$ 63,425	$	$ 1,262,664	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Roofing			1989	1,625		5			1,625	9
10	Carpeting			1990	936		3			936	10
11	Heater / A-C			1990	17,400		5			17,400	11
12	Improvements			1991	1,563		10			1,563	12
13	Water Heater			1991	961		10			961	13
14	Door Frame Molding			1991	527		10			527	14
15	Doors			1991	738		10			738	15
16	Water Heater			1992	1,749		10			1,749	16
17	Handrails			1992	584		10			584	17
18	Roofing			1992	2,258		10			2,258	18
19	Water Line			1992	755		10			755	19
20	Smoke Dampers			1993	2,400	220	10	220		2,400	20
21	Blacktop Driveway			1993	10,130	1,013	10	1,013		9,792	21
22	Install Duct Runs			1994	750	75	10	75		713	22
23	Remodel Laundry Room			1994	3,154	315	10	315		2,967	23
24	Weather-Stripping Replacement			1994	1,849	185	10	185		1,742	24
25	Remodel Laundry Room			1994	2,063	206	10	206		1,923	25
26	A/C Roof Top Unit			1994	8,985	899	10	899		8,091	26
27	Install Sump Pump and Man Hole			1994	3,200	320	10	320		2,800	27
28	Anti-Scald Valve			1995	696	70	10	70		583	28
29	Alarm Ansul System			1995	1,253	125	10	125		1,042	29
30	Garbage Disposal			1995	1,067	107	10	107		865	30
31	Water Booster System Replacement			1995	6,941	694	10	694		5,899	31
32	Carpet for Offices			1995	2,432	243	10	243		2,019	32
33	Strip/Seal North Parking Lot			1995	3,382	338	10	338		2,648	33
34	Additional Parking Spaces			1995	2,375	237	10	237		1,837	34
35	Replace Gutters & Down Spouts			1995	2,150	215	10	215		1,702	35
36	Install New Windows			1995	2,588	258	10	258		1,957	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Walter Lawson Children's Home # 0035469 Report Period Beginning: 07/01/02 Ending: 06/30/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Gazebo Building	1995	$ 1,676	$ 168	10	$ 168	$	$ 1,274	37
38	Tile Kitchen Floor	1996	5,187	519	10	519		3,892	38
39	Bi-Fold Mirror Doors	1996	699	70	10	70		519	39
40	Clear Theralite Window Panel	1996	730	73	10	73		541	40
41	Remodel Kitchen - Ceiling Tiles	1996	279	28	10	28		205	41
42	Install Water Heater	1996	4,981	498	10	498		3,652	42
43	Install Hatco Water Heater	1996	1,550	155	10	155		1,137	43
44	New Roof on West Entrance	1996	1,150	115	10	115		834	44
45	Install New Mixing Valve	1996	2,960	296	10	296		2,146	45
46	Service Sink	1996	644	64	10	64		443	46
47	Vinyl Replacement Windows	1996	1,725	173	10	173		1,167	47
48	Install Water Heater	1997	6,014	601	10	601		3,857	48
49	Shower Trolley	1997	10,924	1,092	10	1,092		6,916	49
50	Stonebridge Tile-Bathing Area	1997	666	67	10	67		424	50
51	Drain, Lines, Vent Shower Trolley	1997	1,340	134	10	134		849	51
52	Install 175 Watt Fixture	1997	1,427	143	10	143		906	52
53	Replace Temperature Control Board - A/C	1997	1,021	102	10	102		638	53
54	Water Circulation Pump	1997	675	68	10	68		414	54
55	Re-Roof North Wing, Gravel Roof	1997	27,597	2,760	10	2,760		16,789	55
56	Parking Lot	1997	9,898	990	10	990		5,775	56
57	Fence	1997	5,680	568	10	568		3,266	57
58	Dirt & Sod	1997	1,075	108	10	108		612	58
59	Reinstall AC Roof Top Unit	1997	2,975	297	10	297		1,782	59
60	Security System	1997	2,362	236	10	236		1,396	60
61	Hopper Service Sink	1997	660	66	10	66		385	61
62	Install Frame/Door	1997	1,135	57	20	57		323	62
63	Education Wing	1997	137,582	6,879	20	6,879		38,981	63
64	Contractor's Fee - Education Wing	1997	73,788	3,689	20	3,689		20,905	64
65	V.C. Tile	1997	610	31	20	31		175	65
66	Contractor's Fee - Education Wing	1997	40,125	2,006	20	2,006		11,368	66
67	Install Fire Alarm Panel	1997	700	35	20	35		198	67
68	Ductwork On Roof	1997	538	27	20	27		153	68
69	Re-locate Roof Top Unit	1998	4,712	236	20	236		1,337	69
70	TOTAL (lines 4 thru 69)		$ 3,354,596	$ 91,296		$ 91,296	$	$ 1,473,999	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Walter Lawson Children's Home # 0035469 Report Period Beginning: 07/01/02 Ending: 06/30/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,354,596	$ 91,296		$ 91,296	$	$ 1,473,999	1
2	Grade & Sod	1998	520	52	10	52		295	2
3	Contractor's Fee - Education Wing	1998	26,724	1,336	20	1,336		7,571	3
4	Replace Blower Motor	1998	620	62	10	62		346	4
5	Pour New Concrete	1998	945	95	10	95		522	5
6	Install Emergency Generator	1998	85,328	8,533	10	8,533		46,931	6
7	Cabinets & Countertops	1998	788	79	10	79		434	7
8	Replace Inducer Motor	1998	837	84	10	84		455	8
9	Replace Heat Exchanger, Burners & Deflection Plate	1998	1,228	123	10	123		656	9
10	Install New Receptacle, Box & Separated Circuits	1998	1,639	164	10	164		875	10
11	Roof	1998	700	70	10	70		367	11
12	Install Thermaltite Window	1998	570	57	10	57		295	12
13	Blacktop New Parking Lot and Driveway	1998	9,752	975	10	975		4,875	13
14	Install New Aluminum Siding/Install New Gutter	1998	1,397	140	10	140		700	14
15	Replace Gas Valve, Thermostats, Circuit Board, Ignitor	1998	1,008	101	10	101		480	15
16	Install New Roof-Top Heating / Air Conditioning Unit	1999	4,340	434	10	434		1,953	16
17	Re-Tile Bathtub Room Floor and Walls	1999	2,080	208	10	208		936	17
18	New Bathtub, Install Drain, Vent, Water Lines	1999	1,780	178	10	178		786	18
19	Install New Sink	1999	676	68	10	68		311	19
20	Heat Exchanger	1999	912	91	10	91		394	20
21	Roof-Top Unit Replace Motor	1999	731	73	10	73		303	21
22	Tear Off and Replace Roof	1999	2,500	125	20	125		500	22
23	Install New Roof Shingles, Facia Boards & Vents	1999	3,727	186	20	186		682	23
24	Furnish and Install True 2-Door Freezer	1999	3,265	218	15	218		799	24
25	Install New Heat Exchanger	2000	730	49	15	49		171	25
26	Extension and Enlargement of Sewer System Pipes	2000	1,804	120	15	120		420	26
27	Installed New 50 Gallon Water Heater	2000	918	61	15	61		203	27
28	New Toshiba Strata Digital Telephone System	2000	3,264	326	10	326		1,087	28
29	New Toshiba Strata Digital Telephone System	2000	6,528	653	10	653		2,177	29
30	New Toshiba Strata Digital Telephone System	2000	1,478	148	10	148		493	30
31	Tear Off and Replace North Flat Roof	2000	1,147	57	20	57		181	31
32	Replace Concrete at Pavillion	2000	2,700	180	15	180		510	32
33	Cement Walk & Landscaping to Prevent Flooding	2000	900	60	15	60		165	33
34	TOTAL (lines 1 thru 33)		$ 3,526,132	$ 106,402		$ 106,402	$	$ 1,550,872	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Walter Lawson Children's Home # 0035469 Report Period Beginning: 07/01/02 Ending: 06/30/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 3,526,132	$ 106,402		$ 106,402	$	$ 1,550,872	1
2	Seal and Stripe Parking Lot	2000	1,600	160	10	160		440	2
3	Install Two RPZ Backflow Preventor	2000	2,445	163	15	163		462	3
4	Fire Sprinkler System Installation	2001	37,774	1,511	25	1,511		3,777	4
5	New Laundry Room Air Intake Filter	2001	623	25	25	25		56	5
6	Sprinkler System Valve	2001	2,200	88	25	88		191	6
7	Duro-Last Roof System Installation	2001	40,846	1,634	25	1,634		3,540	7
8	Trolly Shower Mattress	2001	900	90	10	90		180	8
9	New Door	2001	2,085	139	15	139		266	9
10	Booster Pump	2001	4,838	322	15	322		510	10
11	Cornice	2001	859	57	15	57		105	11
12	Nurse's Station	2001	6,594	440	15	440		770	12
13	Fover Carpet	2001	2,341	234	10	234		410	13
14	Internet Wiring	2002	2,341	156	15	156		221	14
15	Install Steel Door Frame	2002	1,485	83	15	83		83	15
16	New Heat Exchanger	2002	2,818	157	15	157		157	16
17	Gutters & Downspouts	2002	900	75	10	75		75	17
18	Internal Parts Tempering	2002	1,356	102	10	102		102	18
19	Classroom Tile	2002	500	33	10	33		33	19
20	Heat Exchanger	2002	1,106	37	15	37		37	20
21	Remodeling Project	2003	3,541	30	10	30		30	21
22	Remodeling Project	2003	702	6	10	6		6	22
23	Rounding			(3)		(3)		1	23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,643,986	$ 111,941		$ 111,941	$	$ 1,562,324	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Walter Lawson Children's Home # 0035469 Report Period Beginning: 07/01/02 Ending: 06/30/03

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 50,053	$ 7,715	$ 7,715	$		$ 27,905	71
72	Current Year Purchases	10,089	801	801			801	72
73	Fully Depreciated Assets	504,120	1,329	1,329			504,120	73
74	Corporate Allocation		17	17				74
75	TOTALS	$ 564,262	$ 9,862	$ 9,862	$		$ 532,826	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Staff & Patient Transportatio	1997 Ford Club Wagon	1990	$ 3,120	$	$	$	3	$ 3,120	76
77	Staff & Patient Transportatio	A/C For Ford Club Wagon	1998	1,040				3	1,040	77
78	Staff & Patient Transportatio	1999 Dodge Van	1999	22,678	4,536	4,536		5	20,410	78
79	Staff & Patient Transportatio	Chevrolet Van	2001	20,500	4,100	4,100		5	6,492	79
80	TOTALS			$ 47,338	$ 8,636	$ 8,636	$		$ 31,062	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,940,014	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 130,439	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 130,439	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,126,212	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	Hydro Therapy Construction	$ 1,350	92
93			93
94			94
95		$ 1,350	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Walter Lawson Children's Home # 0035469 Report Period Beginning: 07/01/02 Ending: 06/30/03

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Not Applicable

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 5,479 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Transportation	2001 Mercury Sable	$ 608.19	$ 7,298	17
18					18
19					19
20					20
21	TOTAL		$ 608.19	$ 7,298	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Walter Lawson Children's Home # 0035469 Report Period Beginning: 07/01/02 Ending: 06/30/03

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Walter Lawson Children's Home **#** 0035469 **Report Period Beginning:** 07/01/02 **Ending:** 06/30/03

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 06/30/03 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 767	$	1
2	Cash-Patient Deposits	57,160		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (1,900))	1,027,643		3
4	Supply Inventory (priced at Cost)	16,587		4
5	Short-Term Investments			5
6	Prepaid Insurance	(25,853)		6
7	Other Prepaid Expenses	1,684		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due from Corporate	673,008		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,750,996	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	684,428		13
14	Buildings, at Historical Cost	3,643,986		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	611,600		16
17	Accumulated Depreciation (book methods)	(2,126,212)		17
18	Deferred Charges	315,038		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	2,336		21
22	Other Long-Term Assets (specify):	513,782		22
23	Other(specify): Goodwill	356,917		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 4,001,875	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,752,871	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 42,604	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	57,160		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	189,303		30
31	Accrued Taxes Payable (excluding real estate taxes)	6,100		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	33,689		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 328,856	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	5,565,000		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 5,565,000	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,893,856	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (140,985)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,752,871	$	48

***(See instructions.)**

Facility Name & ID Number Walter Lawson Children's Home # 0035469 Report Period Beginning: 07/01/02 Ending: 06/30/03

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (378,404)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (378,404)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	237,419	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 237,419	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (140,985)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Walter Lawson Children's Home # 0035469 Report Period Beginning: 07/01/02 Ending: 06/30/03

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,357,964	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,357,964	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education	656,144	9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 656,144	23
	D. Non-Operating Revenue		
24	Contributions	42,099	24
25	Interest and Other Investment Income***	28,165	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 70,264	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	DMH Day Training	501,403	28
28a	Miscellaneous Income	79,149	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 580,552	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,664,924	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	821,821	31
32	Health Care	2,505,027	32
33	General Administration	1,365,942	33
	B. Capital Expense		
34	Ownership	574,022	34
	C. Ancillary Expense		
35	Special Cost Centers	842,305	35
36	Provider Participation Fee	318,388	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,427,505	40
41	**Income before Income Taxes (line 30 minus line 40)****	237,419	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 237,419	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Walter Lawson Children's Home # 0035469 Report Period Beginning: 07/01/02 Ending: 06/30/03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,038	2,086	$ 67,834	$ 32.52	1
2	Assistant Director of Nursing					2
3	Registered Nurses	16,374	18,108	403,095	22.26	3
4	Licensed Practical Nurses	18,536	20,622	447,332	21.69	4
5	Nurse Aides & Orderlies	113,666	122,049	1,283,856	10.52	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	1,997	2,065	56,083	27.16	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	11,155	11,808	82,485	6.99	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	1,971	2,242	38,041	16.97	13
14	Head Cook	5,522	6,061	85,781	14.15	14
15	Cook Helpers/Assistants	3,333	3,725	38,253	10.27	15
16	Dishwashers	1,713	1,800	12,853	7.14	16
17	Maintenance Workers	1,807	2,126	51,682	24.31	17
18	Housekeepers	13,702	15,306	182,857	11.95	18
19	Laundry	8,466	9,328	86,277	9.25	19
20	Administrator	2,015	2,063	93,228	45.19	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,148	3,573	67,638	18.93	24
25	Vocational Instruction					25
26	Academic Instruction	36,171	38,799	594,211	15.32	26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	4,786	5,372	81,953	15.26	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Day Training	8,675	9,217	102,447	11.12	33
34	TOTAL (lines 1 - 33)	255,075	276,350	$ 3,775,906 *	$ 13.66	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	228	$ 9,132	1.3	35
36	Medical Director	N/A	11,205	9.3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	621	37,260	10a.3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Dental Fees	N/A	8,933	10.3	46
47	Education	26	720	43.3	47
48	Medical	12	1,800	10.3	48
49	TOTAL (lines 35 - 48)	887	$ 69,050		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Walter Lawson Children's Home # 0035469 Report Period Beginning: 07/01/02 Ending: 06/30/03

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Theo Brandel	Administrator	0	$ 93,228
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 93,228

B. Administrative - Other

Description	Amount
Corporate Expenses	$ 138,754
TOTAL (agree to Schedule V, line 17, col. 3)	$ 138,754
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Medical Rehabilitation		$
Centers, Inc.	Management Fees	355,200
Thomas Healthcare Consulting	Accounting Fees	3,600
Miscellaneous	Legal Fees	731
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 359,531

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 62,805
Unemployment Compensation Insurance	16,412
FICA Taxes	284,514
Employee Health Insurance	244,478
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Benefits - Other	13,670
Corporate Allocation	6,068
TOTAL (agree to Schedule V, line 22, col.8)	$ 627,947

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
None		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 400
Advertising: Employee Recruitment	
Health Care Worker Background Check	929
(Indicate # of checks performed 75)	
Illinois Health Care Assoc.	4,593
MES of Illinois	175
Corporate Allocation	104
Other Fees	4,951
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 11,152

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 1,390
Non-Allowable Travel	(1,390)
In-State Travel	12,832
Non-Allowable Travel	(3,207)
Seminar Expense	540
Corporate Allocation	1,409
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 11,574

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Walter Lawson Children's Home # 0035469 Report Period Beginning: 07/01/02 Ending: 06/30/03

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	None		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Walter Lawson Children's Home **#** 0035469 **Report Period Beginning:** 07/01/02 **Ending:** 06/30/03

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **See Schedule XIX, Section F**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **19,748** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **318,388**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **Yes** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **N/A**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **79,149**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **Yes**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100%**
d. Have vehicle usage logs been maintained? **Yes (Owned) No (Leased)**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Resnick, Fedder, & Silverman** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **Yes** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.